Care Assessment for Residential Services Tool

Trained personnel may complete all sections of this assessment. Collaboration or consulting with health care professionals, their examinations or progress notes is essential to ensure the assessment is accurately completed.

Resident Name: _____ Date of Assessment: _____

Resident DOB: _____ Date of Admission: _____

Initial/Admission Assessment ☐ Six-Month Assessment ☐ Change in Status Assessment ☐

Section I. MEDICAL/NURSING

Current Diagnoses

Initial/Admission Assessment- Attach current diagnosis list.

Six-Month or Change of Status Assessment- Write in new or discontinued diagnoses. Attach new diagnosis list if more than five changes.

Diagnosis	Date	Diagnosis	Date

Current Medications/Treatments

Initial/Admission Assessment- Attach active medication/treatment list.

Six-Month or Change of Status Assessment- Write in new or discontinued medications/treatments. Attach new medication/treatment list if more than four changes.

	Yes	No	Comment:
Provider orders signed and dated for current medications and treatments			

Medication/Treatment changes since last C.A.R.E.S Assessment:	Date

	Yes	No	Comment:
Nutritional Status			
1. Special dietary need. If yes, specify.			
2. Requires adaptive eating utensils. If yes, specify.			
3. Weight change of 5% or more in the past 30 days. If yes, specify.			

	Yes	No	Comment:
Medication Administration			
1. Responsible for self-administration. (If resident requires self-direct medication administration, note in comments.)			Annual Physician order for self-administration? YES or NO Bi-Annual Evaluation Complete? YES or NO
2. Requires supervised self-administration.			
3. Requires nurse or other licensed personnel to give all medications.			

	Yes	No	Comment:
Hospice Services			
1. Currently receiving hospice services. (If no, skip to next section)			
2. Hospice admitted orders signed and dated.			
3. Hospice Provider Contact Information:			

	Yes	No	Comment:
Wound Care			
1. Currently receiving wound care services. (If no, skip to next section)			

2. Wound care orders signed and dated.			
3. Wound Care Provider Contact Information:			

Section II. ADL Functions

	Yes	No	Comment:
1. Requires assistance with incontinent products.			If yes, circle level of assistance required: SET UP or ONE PERSON
2. Requires assistance with toileting.			If yes, circle level of assistance required: SET UP or ONE PERSON
3. Requires assistance with dressing.			If yes, circle level of assistance required: SET UP or ONE PERSON
4. Requires assistance with bathing.			If yes, circle level of assistance required: SET UP or ONE PERSON
5. Requires assistance with dental care. (Circle: FULL PARTIAL BRIDGE)			If yes, circle level of assistance required: SET UP or ONE PERSON

Section III. SAFETY

	Yes	No	Comment:
WALKING/AMBULATION/TRANSFERS			
1. Independent with ambulation.			If no, circle level of assistance required: SUPERVISION or ONE PERSON
2. Walks with assistive equipment for ambulation. (If yes, list equipment.)			

3. Independent with stair navigation.			If no, circle level of assistance required: SUPERVISION or ONE PERSON
4. Needs physical assistance to transfer.			If yes, circle level of assistance required: ONE PERSON or TWO PERSON
5. Requires Hoyer lift or other lift equipment to transfer.			

	Yes	No	Comment:
FALLS			
1. Diagnosis of gait or balance impairment.			
For six-month or change of status assessment **only**. 2. Documented falls in last six months. (If yes, write in how many.)			

	Yes	No	Comment:
EVACUATION (Select level of assistance necessary for safe evacuation.)			
1. Evacuates building independently.			
2. Evacuates building with verbal assist.			
3. Evacuates building with physical assist.			If yes, circle level of assistance required: ONE PERSON or TWO PERSON

Section IV. COGNITIVE, MENTAL AND BEHAVIORAL HEALTH

	Yes	No	Comment:
COGNITIVE, MENTAL AND BEHAVIORAL HEALTH STATUS			
1. Active diagnosis of cognitive/memory impairment, including dementia. (If yes, list in comment section.)			
2. Displays exit-seeking behaviors.			
3. Active diagnosis of mental health condition, including depression, anxiety, schizophrenia, etc. (If yes, list in comment section.)			
4. Actively pursuing mental health treatment or services. (If yes, list in comment section.)			

	Yes	No	Comment:
COMMUNICATION			
1. Requires corrective lenses or reading glasses.			(Circle one: Daily Reading Both)
2. Requires hearing aids.			(Circle one: Right Left Both)
3. Effective communication. (If no, list barriers.)			

Section V. LEGAL

	Yes	No	Comment:
1. Advanced Directives Completed.			
2. Activated DPOA-HC, or Guardian. (If yes, list Activated DPOA-HC or Guardian.)			
3. POLST Completed.			
4. Code Status. (Circle one: FULL CODE or DNR) (Circle one: If DNR, PINK form in facility- YES or NO)			

ACCEPTABLE REASONS FOR ABSENCE OF CARE PLAN FOR A NEED IN A SHADED BOX

Reason A = This need is met for all residents as part of the basic services and all staff provide this need per their job description, responsibilities and / or facility policy.

Reason B = This need is met by other health care professionals not employed by the facility but with oversight provided by facility staff.

Reason C = The facility, and others, have exhausted all reasonable attempts to meet this need. The resident, legal agent and family are aware and agree this need will not have a care plan.

Reason D = Other. Provide explanation below.

_____

_____

_____

Completed by: _____ _____ _____ _____
Name (printed) Signature Date Title

All assessments must be completed and reviewed in collaboration with resident or their guardian, agent, or personal representative, if any.

Reviewed by: _____ _____ _____ _____
Name (printed) Signature Date Relationship

Reviewed by: _____ _____ _____ _____
Name (printed) Signature Date Relationship